NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Consumer & Industry Services
Bureau of Workers' Disability Compensation
P.O. Box 30016, Lansing, MI 48909

Filing #: 8

PART A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth	5. Date of Death
[redacted]	11/14/2008	SHERITA R. ODUM	10/04/1973	

6. Employee Street Address	7. City	8. State	9. Zip Code
[redacted]	REDFORD	MI	48239

10. Employer Name	11. Federal ID Number	12. Injury Location Code
Beaumont Hospitals	381459362	

13. Employer Street Address	14. City	15. State	16. Zip Code
550 StephensonH	Troy	MI	48085

17. Carrier or Self-Insured Name	18. NAIC or Self-Insured Number
Beaumont Hospitals	80000882

19. Service Company/TPA Name (if applicable)	20. Service Company/TPA ID Number
Sedgwick Claims Management Services	A90

21. Zip Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury	24. Date First Payment Made
48084	30081113686-0001	11/17/2008	

PART B

25. Nature of Injury	26. Part of Body
Contusion right elbow	Elbow

27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A. W. W.	30. Second Employer Discontinued Fringes
642.78			

31. Tax Filing Status on Date of Injury	32. Last Day Worked	33. Number of Days in Work Week	34. Number of Dependents
B	11/14/2008	7	0

PART C

35. Reason For Filing	36. Weekly Compensation Base Rate
F	419.14

37. Weekly Adjustments to Base Rate

Q	$ 317.39	$	$	$
	$	$	$	$

38. Weekly Amount Being Reimbursed by a Fund (Not reported in line 37)

$	$	$	$

PART D

BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROUGH	TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON
A	A		419.14	01/01/2011	06/12/2011	9,759.97	2011	
A	A		101.75	6/13/2011				

IF BASIS OF PAYMENT IS OTHER THAN "A" (VOLUNTARY PAYMENT) OR LINE 37 IS EQUAL TO "J" OR "K", ENTER ORDER #

IF BENEFIT TYPE IS "C" (SPECIFIC LOSS), ENTER NUMBER OF WEEKS AND EFFECTIVE DATE OF LOSS

IF ANY FILING CODES ON THIS FORM REPRESENT "OTHER", PLEASE BE SPECIFIC Wages reduced based on Stokes/Lofton

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

Authority: Workers' Disability Compensation Act, 408.31 (6a-d)
Completion: Mandatory
Penalty: Workers' Disability Compensation Act, 418.631; 418.801

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE

39. Authorized Signature	40. Person Handling Claim	41. Telephone Number	42. Date
	Ann Marie Roberts	(248)637-4286	09/12/2011

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

WC-701 (Rev. 1/09) FRONT